

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/05/2012
FORM APPROVED
OMB NO. 0938-0391

POC # 3
acceptable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2012
NAME OF PROVIDER OR SUPPLIER BROOKWOOD NURSING CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>An annual recertification survey was conducted on September 24, 2012, through October 1, 2012.</p> <p>The facility was cited an Immediate Jeopardy at F-272, F-280, F-323, F-490 and F-520 for failing to complete assessments, failure to develop/update care plans, failure to supervise, failure to identify problems and implement a plan, and failure to be administered in a manner to promote safe smoking for six (#9, #34, #53, #58, #80, #81) residents. The facility's failure to ensure safe smoking practices was likely to cause serious injury, harm, impairment, or death to residents #9, #34, #53, #58, #80, #81) and potentially for all residents in the facility who smoke.</p> <p>An extended survey was completed on October 1, 2012.</p> <p>The Administrator and the Director of Nursing were informed of the Immediate Jeopardy on September 26, 2012, at 4:00 p.m., in the conference room.</p> <p>The Immediate Jeopardy was effective from September 22, 2012, through October 1, 2012. Substandard Quality of Care was cited under F323-K. An acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated on-site by the survey team on October 1, 2012.</p> <p>Non compliance of the Immediate Jeopardy tag F272 continues at . scope and severity level "D"</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Steve E. Stephens Administrator POC# 3 10.18.12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 and non compliance of the Immediate Jeopardy tags F280, F323, F490, and F520 continues at a scope and severity of a "E" level for monitoring of corrective actions and evaluation by the facility's quality assessment and assurance committee.	F 000	This plan of correction is our credible allegation of compliance.		
F 157 SS=D	The facility is required to submit a plan of correction for all cited deficiencies. 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	"Preparation and/or execution of correction does not constitute admission or agreement by the provider, of the truth of the facts alleged or deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law." F-157- What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? 1. The physician was notified on 9/27/12 by DON of the weight loss for resident #38 who had experienced a slow, steady, weight loss over several months that did not trigger as a significant weight loss when the weights were calculated by the facility CDM. 2. MD was notified by DON of weight loss 9/27/12 and stated that with patient's extent of dementia the weight loss is to		

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F 157	<p>Continued From page 2</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to notify the physician of a significant weight loss for one resident (#38), and of a psychiatric recommendation for one resident (#17) of forty-three residents reviewed. The findings included:</p> <p>Resident #38 was admitted to the facility on April 18, 2012, with diagnoses including Dementia, Senile Delusions, Hypertension, and Acute Bronchitis.</p> <p>Medical record review of the quarterly Minimum Data Set dated July 23, 2012, revealed the resident had short and long term memory problems, had severely impaired cognitive skills, and required limited assistance with eating.</p> <p>Medical record review of the nursing notes revealed the resident was transferred to the hospital on August 14, 2012, and returned to the facility on August 17, 2012.</p> <p>Medical record review of a hospital Discharge Summary dated August 17, 2012, revealed the resident was treated with IV (intravenous) antibiotics and nebulizer treatments due to Dementia with Bibasilar Aspiration Pneumonia.</p> <p>Medical record review of the Weight Flow Sheet</p>	F 157	<p>be expected and wished to not intervene at present time.</p> <p>3. The physician was notified on 9/27/12 by the DON, of the psychiatric consult recommendation for medication adjustments for resident #17.</p> <p>4. The physician has agreed to the recommendation and an order was received from the MD for medication adjustment.</p> <p>How will you identify other residents having the potential to be affected by the same alleged practice(s) and what corrective action will be taken?</p> <p>1. All current medical records were audited by the DON and ADON on 9/28/12, to ensure no other recommendations for medication adjustments had been filed on the medical record prior to orders being written following MD approval for recommendation. The CDM reviewed weights of all residents and provided the DON with a list of all residents with weight loss and the MD</p>		

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F 157	<p>Continued From page 3</p> <p>revealed the resident weighed 156.4 pounds on June 4, 2012, 145 pounds on August 17, 2012, and 136.6 pounds on September 18, 2012, (a loss of 8.4 pounds or 5.79% since August 17, 2012, and a loss of 19.8 pounds or 12.65% since June 4, 2012).</p> <p>Medical record review revealed no documentation the physician was notified of the resident's weight loss.</p> <p>Review of the facility's policy Weight Monitoring Standards revealed "...Unplanned and undesired weight variance will be evaluated for significance utilizing the following guidelines:...one month 5%...six months 10%...If there is an actual 5% or more gain or loss in one month, the...physician and the Dining Services Director are notified by the Nursing Department..."</p> <p>Observation on September 27, 2012, at 12:15 p.m., revealed the resident seated at the restorative dining table in the dining room. Continued observation revealed the resident had consumed a grilled cheese sandwich, approximately 1/2 of a barbeque sandwich, 100% of slaw, approximately 90% of baked beans, approximately 130 ml (milliliters) of whole milk, and 100% of the Boost (nutritional supplement).</p> <p>Interview on September 27, 2012, at 9:50 a.m., with the Certified Dietary Manager in the lobby revealed the resident had received Boost twice a day since admission to the facility and snacks three times a day.</p> <p>Interview on September 27, 2012, at 12:30 p.m., with the Director of Nursing (DON), in the DON's</p>	F 157	<p>was notified on 10/6/12.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the alleged deficient practice(s) does/do not reoccur?</p> <ol style="list-style-type: none"> 1. The Social Service Director will be responsible for getting the psych. recommendations to the DON or ADON when received and the CDM will be responsible for getting the weight report to the DON and ADON monthly when completed. The DON and ADON will review consultant recommendations for needed action prior to recommendation reports being placed in the resident's medical records. DON or ADON will notify MD/family of significant weight loss when identified as a medical problem. 2. The licensed staff were in-serviced on physician and family notifications on 10/08/12 by the DON. <p>How will the corrective action(s) be monitored to ensure the alleged</p>	11/15/12	

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F 157	<p>Continued From page 4</p> <p>office, confirmed the physician had not been notified of the resident's significant weight loss.</p> <p>Telephone interview on September 27, 2012, at 2:05 p.m., with the physician revealed the resident had Advanced Dementia and it was not unusual for residents with Advanced Dementia to start eating less. Continued interview revealed if the physician had been notified of the resident's weight loss, no additional orders would have been given to the nursing staff.</p> <p>Resident #17 was admitted to the facility on June 13, 2011, with diagnoses including Alzheimer's Disease, Depressive Disorder, Anxiety State, Chest Pain, Anemia, Hypertension, Hearing Loss, Coronary Artery Disease, Gastro-Esophageal Reflux, Chronic Obstructive Pulmonary Disease, and Psychosis.</p> <p>Medical record review of a psychiatric consult dated August 5, 2012, revealed the resident was paranoid, anxious, depressed, was alert and had poor judgment. Continued review of the psychiatric consult revealed a recommendation to reduce Geodon (antipsychotic) to 40 mg (milligrams) for three days at 8:00 p.m., then 20 mg for 2 days, then stop...and to increase the Depakote (mood stabilizer) to 250 mg twice a day.</p> <p>Medical record review of the August 2012, physician's orders revealed the resident was to receive Geodon (antipsychotic medication) 60 mg (milligrams) every evening, and Depakote 125 mg twice daily.</p> <p>Medical record review of the August 2012, and</p>	F 157	<p>deficient practice(s) will not reoccur; what quality assurance program will be put into place?</p> <p>1. DON or ADON will report on compliance with notifications to the QA Committee for 3 months, beginning in October.</p>		

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F 157	Continued From page 5 September 1-25, 2012, Medication Records revealed the resident was to receive Depakote 125 mg twice daily and Geodon 60 mg every evening. Medical record review revealed no documentation the physician was notified of the recommendation to decrease the Geodon and increase the Depakote. Observation on September 26, 2012, at 7:25 a.m., revealed the resident sitting on the side of the bed feeding self breakfast. Interview on September 25, 2012, at 3:18 p.m., with the Director of Nursing, in the conference room, confirmed the physician was not notified of the psychiatric recommendation dated August 5, 2012, to decrease the Geodon and increase the Depakote.	F 157			
F 272 SS=J	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision;	F 272	F 272 The facility conducts initial and periodic comprehensive, accurate, standardized reproducible assessments of each resident's functional capacity. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? 1. The smoking assessments for residents #58, #81, #80 were completed on 9/27/12 by the MDS Coordinator.		

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F 272	<p>Continued From page 6</p> <p>Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to assess the smoking habits of three residents (#58, #81, #80) of nineteen residents reviewed for smoking.</p> <p>The facility's failure placed the residents in Immediate Jeopardy (a situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious harm, injury, impairment or death from unsafe smoking).</p> <p>The Nursing Home Administrator (NHA) and the</p>	F 272	<p>How will you identify other residents having the potential to be affected by the same alleged practice(s) and what corrective action will be taken?</p> <p>1. Updated smoking assessments were completed for all current residents who smoke on 9/27/12 by the MDS Coordinator, DON and ADON.</p> <p>What measures will be put into place or what systematic changes will you make to ensure that the alleged deficient practice(s) does not reoccur?</p> <p>1. Smoking Assessments for all residents who smoke will be completed at admission by the admitting charge nurse, and reviewed by the MDS Coordinator, with scheduled RAI assessments, and as needed based on a change in condition. The MDS coordinator will monitor for completion of admission smoking assessments for all new admissions for 3 months beginning in October, and complete updates as indicated on an on-going basis.</p>		

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F 272	<p>Continued From page 7</p> <p>Director of Nursing (DON) were notified of the Immediate Jeopardy on September 26, 2012, at 4:00 p.m., in the conference room.</p> <p>The findings included:</p> <p>Resident #58 was admitted to the facility on September 14, 2012, with diagnoses including Pneumonia, Chronic Airway Obstruction, Dementia with Behavior, Gouty Arthritis, Atrial Fibrillation, Hypertension, and Depressive Disorder.</p> <p>Review of the list of residents identified by the facility as smokers, revealed resident #58 was an active smoker. Medical record review revealed no documentation the resident had been assessed for safe smoking.</p> <p>Interview on September 26, 2012, at 1:57 p.m., with Licensed Practical Nurse (LPN) #3 at the nurse's station, confirmed resident #58 smoked with supervision during designated smoking breaks.</p> <p>Interview with the Director Of Nursing (DON) in the DON's office on Sept. 26, 2012, at 2:15 p.m., confirmed resident #58 had not been assessed for safe smoking.</p> <p>Resident #81 was admitted to the facility on September 12, 2012, with diagnoses including Right Hip Fracture, Urinary Tract Infection, Dementia, and Mild Hypertension.</p> <p>Medical record review of the admission Minimum Data Set dated September 19, 2012, revealed the resident scored 5 out of 15 possible correct</p>	F 272	<p>How will the corrective action(s) be monitored to ensure the alleged deficient practice(s) will not reoccur; what quality assurance program will be put into place?</p> <p>1. Compliance with maintaining accurate, complete smoking assessments as monitored by MDS Coordinator will be reported to the QA Committee (Administrator, DON, ADON, Medical Director, Social Service Director, Certified Dietary Manager, Maintenance Supervisor, Business Office Manager, Housekeeping Supervisor, Restorative Nursing Staff, MDS Coordinator) monthly x 3 months, beginning in October.</p>	10/01/12	

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F 272	<p>Continued From page 8</p> <p>answers on the Brief Interview for Mental Status assessment (BIMS - an assessment for cognitive functioning where a score of 1 to 7 indicates severe cognitive impairment.) Continued review revealed the resident required extensive assistance with transfers, eating, and personal hygiene.</p> <p>Review of the list of residents identified by the facility as smokers, revealed resident #81 was an active smoker.</p> <p>Medical record review of the resident's Safe Smoking Evaluation (undated) revealed the evaluation was a two-sided assessment form and the reverse side of the assessment had not been completed leaving the final determination of the resident's ability to smoke safely unanswered.</p> <p>Interview with the Assistant Director of Nursing (ADON) in the Director Of Nursing (DON) office on September 26, 2012, at 2:30 p.m., confirmed the Safe Smoking Evaluation in the medical record was not complete and did not identify the resident's ability to smoke safely.</p> <p>Resident #80 was admitted to the facility on August 23, 2012, with diagnoses including Urinary Tract Infection, Failure to Thrive, Muscle Weakness, Abnormality of Gait, and Hypothyroidism.</p> <p>Medical record review of the admission Minimum Data Set dated August 30, 2012, revealed the resident scored 14 out of 15 possible correct answers on the BIMS assessment (a score of 13 to 15 indicates mild cognitive impairment). Continued review revealed the resident required</p>	F 272			

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F 272	<p>Continued From page 9</p> <p>extensive assistance with transfers, dressing, personal hygiene, and supervision with set-up help only at mealtime.</p> <p>Review of the list of residents identified by the facility as smokers, revealed resident #80 was an active smoker.</p> <p>Medical record review of the resident's smoking assessment titled, Safe Smoking Evaluation, dated August 13, 2012, revealed the evaluation was a two-sided assessment form, and the reverse side of the assessment had not been completed, leaving the final determination of the resident's ability to smoke safely unanswered.</p> <p>Interview with the Assistant Director of Nursing on September 26, 2012, at 2:30 p.m., in the DON's office, confirmed the resident had not been assessed for safe smoking.</p> <p>The Immediate Jeopardy was effective from September 22, 2012 through October 1, 2012; and was removed on October 1, 2012. An acceptable Allegation of Compliance, which removed the immediacy of the Jeopardy, was received and corrective actions were validated on-site by the survey team on October 1, 2012, through review of facility documents, staff and resident interviews, and observations. The survey team verified the allegation of compliance by:</p> <p>1. Verifying residents #80, #81, and #58, had been reassessed for smoking safety; and verifying the other residents who smoke at the facility had accurate smoking assessments. Accuracy of the smoking assessments was confirmed by the survey team through</p>	F 272			

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F 272	<p>Continued From page 10 observation during smoking sessions.</p> <p>2. Verifying residents #34, #53, #81, #80, #58, and #9 had been educated on the facility's revised smoking policy. The survey team verified the information on interview with resident #58 on September 26, 2012, at 4:00 p.m. The survey team verified the information with resident #53 through observation and interview on September 27, 2012, and interview with #80 on September 27, 2012, at 10:30 a.m.</p> <p>3. Verifying the revision of the facility's smoking policy with acknowledgement of understanding and agreement to the policy by the residents to ensure a safe smoking environment for all residents.</p> <p>4. Verification by the survey team on October 1, 2012, ensured by interviews with multidisciplinary staff, and review of inservice logs confirmed the staff received information regarding the facility's revised smoking policy including staff members are to ensure that all cigarettes and lighters are returned and locked up in the medication room, and that cigarette butts are collected and placed in the locked, metal containers following each smoke break. Residents who are found with cigarettes and/or lighters in their possession will be issued a 30 day discharge notice. Review of documentation confirmed the residents and families of the smoking residents were notified of the revised smoking policy.</p> <p>5. Verifying residents #53, #9, #34, and #58's care plans had been updated to reflect the safety needs for smoking.</p>	F 272			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2012
NAME OF PROVIDER OR SUPPLIER BROOKWOOD NURSING CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD DECATUR, TN 37322		
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F 272	Continued From page 11 Interview with the Director of Nursing October 1, 2012, at 12:50 p.m., revealed members of the Quality Assurance committee (including the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Activity Director, Business Office Manager, Medical Records, Maintenance Supervisor, Certified Dietary Manager, and Housekeeping Supervisor) had met on September 28, 2012, to formulate a plan related to noncompliance with smoking and to develop a plan to ensure resident safety. Continued interview revealed the members of the Quality Assurance committee had revised the facility's Smoking Policy, and inserviced the residents and staff regarding the revised Smoking Policy. Continued interview revealed Social Services had contacted and mailed letters to the families of the residents who smoked, informing them of the facility's Smoking Policy. Continued interview revealed the facility's Medical Director had been made aware of the Immediate Jeopardy on September 28, 2012. Non compliance continues at a "D" level for monitoring corrective actions and evaluation by the facility's Quality Assessment and Assurance Committee. The facility is required to submit a plan of correction for all cited deficiencies.	F 272			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279	F-279 The facility develops comprehensive care plans for each resident that		

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F 279	<p>Continued From page 12</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview the facility failed to develop the comprehensive care plans for one resident #69 for monitoring of thyroid medication, and one resident #35 for pressure ulcer treatment of forty-three residents reviewed.</p> <p>The findings included:</p> <p>Resident #69 was admitted on October 8, 2010, and readmitted on February 13, 2012, with diagnoses including End Stage Renal Disease, Convulsions, Hypertension, Gastroesophageal Reflux Disease, Peripheral Vascular Disease,</p>	F 279	<p>includes measurable objectives and time tables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessments.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <ol style="list-style-type: none"> 1. Resident #69 has had her care plan updated on 10/11/12 by the MDS Coordinator to include monitoring for her hypothyroidism and thyroid medication. 2. Resident #35 care plan includes Risk for Pressure Ulcer Development. The pressure ulcer present upon admission has been resolved. <p>How will you identify other residents having the potential to be affected by the same alleged practice(s) and what corrective action will be taken?</p> <ol style="list-style-type: none"> 1. All current medical records were reviewed by the MDS Coordinator on 10/11/12, to 		

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F 279	<p>Continued From page 13</p> <p>Dementia without Behaviors, Depressive Disorder, Diabetes, and Hypothyroidism.</p> <p>Medical record review of the Physician's Orders dated September 1, 2012, revealed, Levothyroxine Sodium (thyroid medication) 25 mcg (microgram) tablet 1 by mouth every day.</p> <p>Medical record review of the resident's standing orders (undated) signed by the physician, revealed, TSH (Thyroid Stimulating Hormone) q (every) 6 months. Continued medical record review revealed the most recent TSH was completed on February 21, 2012 (a seven month span).</p> <p>Medical record review of the resident's care plan dated August 28, 2012, revealed no evidence the resident's diagnosis/condition of Hypothyroidism had been addressed.</p> <p>Interview with the Minimum Data Set Coordinator (MDS) on October 1, 2012, at 11:22 a.m., in the MDS office, confirmed the TSH had not been addressed on the resident's care plan.</p> <p>Resident #35 was readmitted to the facility on August 7, 2012, with diagnoses including Dementia with Psychosis/Behavior Disturbance, Hypertension, Hypothyroidism, Anxiety Disorder, Fractured Left Hip, and Osteoporosis.</p> <p>Medical record review of the Weekly Pressure Ulcer Record dated August 7, 2012, revealed the resident was admitted with a Stage II (partial thickness) pressure ulcer on the coccyx.</p>	F 279	<p>identify any residents with thyroid disorders and/or being treated with thyroid medications to ensure that the plan of care covered the services being provided to these residents.</p> <p>2. The Treatment nurse reviewed the medical records for residents with pressure ulcers, and at risk for pressure ulcer development on 10/11/12; no additional residents were found to have been admitted to the facility with pressure ulcers or risk for development of pressure ulcers that failed to be addressed on the Plan of Care.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the alleged deficient practice(s) does/do not reoccur?</p> <p>1. The MDS coordinator was inserviced on 10/15/12 by the DON, on the inclusion of problems to the care plan to address all medications and services being provided to the resident's. The nursing staff will</p>		

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F 279	<p>Continued From page 13</p> <p>Dementia without Behaviors, Depressive Disorder, Diabetes, and Hypothyroidism.</p> <p>Medical record review of the Physician's Orders dated September 1, 2012, revealed, Levothyroxine Sodium (thyroid medication) 25 mcg (microgram) tablet 1 by mouth every day.</p> <p>Medical record review of the resident's standing orders (undated) signed by the physician, revealed, TSH (Thyroid Stimulating Hormone) q (every) 6 months. Continued medical record review revealed the most recent TSH was completed on February 21, 2012 (a seven month span).</p> <p>Medical record review of the resident's care plan dated August 28, 2012, revealed no evidence the resident's diagnosis/condition of Hypothyroidism had been addressed.</p> <p>Interview with the Minimum Data Set Coordinator (MDS) on October 1, 2012, at 11:22 a.m., in the MDS office, confirmed the TSH had not been addressed on the resident's care plan.</p> <p>Resident #35 was readmitted to the facility on August 7, 2012, with diagnoses including Dementia with Psychosis/Behavior Disturbance, Hypertension, Hypothyroidism, Anxiety Disorder, Fractured Left Hip, and Osteoporosis.</p> <p>Medical record review of the Weekly Pressure Ulcer Record dated August 7, 2012, revealed the resident was admitted with a Stage II (partial thickness) pressure ulcer on the coccyx.</p>	F 279	<p>be in-serviced by the DON on 10/23/12, on the Interim Plan of Care addressing pressure ulcers and risk for pressure ulcer development on admission.</p> <p>How will the corrective action(s) be monitored to ensure the alleged deficient practice(s) will not reoccur; what quality assurance program will be put into place?</p> <ol style="list-style-type: none"> 1. The DON &/or ADON have reviewed all current care plans and will review 3 care plans weekly to monitor for compliance and report the findings to the QA committee x 3 months, beginning in October. 	11/15/12	

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F 279	Continued From page 14 Medical record review of the resident's interim care plan dated August 7, 2012, and the initial care plan dated August 16, 2012, revealed no documentation the pressure ulcer had been included on the care plan. Review of the facility's Pressure Ulcer Policy, revealed, an interim care plan is to be completed on admission. Interview with the Director of Nursing (DON) on September 25, 2012, at 3:15 p.m., in the conference room confirmed the interim care plan and the initial care plan had not addressed the resident's Stage 2 pressure area.	F 279			
F 280 SS=K	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280	F 280 The facility reviews and revises resident's care plans periodically as indicated. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? 1. Resident's #53, #9, #34, #58 care plans have been updated for safe smoking interventions on 9/29/12 by the ADON.		

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F 280	<p>Continued From page 15</p> <p>legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to update the care plan for four residents (#53, #9, #34 #58) for safe smoking interventions and for one resident (#55) for a urinary tract infection of forty-three residents reviewed.</p> <p>The facility's failure placed resident #53, #9, #34, and #58 in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death) from unsafe smoking.</p> <p>The Nursing Home Administrator (NHA) and the Director of Nursing (DON) were notified of the Immediate Jeopardy on September 26, 2012, at 4:00 p.m., in the conference room.</p> <p>The findings included:</p> <p>Resident #53 was admitted to the facility on August 20, 2010, with diagnoses including Dementia with Behaviors, Diabetes Mellitus, Depressive Disorder, and Hypertension.</p> <p>Medical record review of the Annual Minimum Data Set dated August 10, 2012, revealed the resident scored 15 out of 15 on the Brief Interview</p>	F 280	<p>Resident #55's care plan was updated on 9/25/12 by the MDS Coordinator, to include her UTI, and updated with resolution.</p> <p>How will you identify other residents having the potential to be affected by the same alleged practice(s) and what corrective action will be taken?</p> <p>1. All current smoking residents care plans have been reviewed and updated as needed to include safe smoking interventions and incorporated revised smoking policy interventions by the MDS Coordinator and ADON on 9/29/12. All new admissions with smoking history will have care plans to include the above.</p> <p>What measures will be put into place or what systematic changes will you make to ensure that the alleged deficient practice(s) does/do not reoccur?</p> <p>1. The MDS coordinator was in-serviced by the DON on 10/15/12, on care plan updates</p>		

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F 280	<p>Continued From page 16</p> <p>for Mental Status (BIMS-an assessment to determine cognitive abilities with a score of 13-15 indicating cognitively intact and was independent with ambulation.</p> <p>Medical record review of the Quarterly Assessment for Smoking Safety dated August 10, 2012, revealed "...Smokes safely with minimal supervision...Smoking apron...Facility storage of tobacco products...Assistance with lighting tobacco products...Supervised smoking by staff..."</p> <p>Medical record review of the care plan dated August 10, 2012, revealed "...At risk for injury (related to) smoking status. (resident #53) requires supervision for safety with facility smoking policy..."</p> <p>Medical record review of a nurse's note dated February 17, 2012, revealed "... (2:40 a.m.) This nurse was on lunch in smoking area (with) a CNA. (certified nursing assistant) Res.(resident) came out to smoke area and said, "will you do me a favor?" This nurse stated, "You know I can't permit you to smoke until it's your scheduled smoke time."...This nurse (and) CNA returned into facility (and) res did not follow (and) was not visible. This nurse...went outside (and) observed res. digging in stand up ash bin...had removed the top (and) was bent over smoking the cig's (cigarettes) that were put in there still lit. Res. was informed that it was unsanitary (and)...needed to return to...(room)...Res. cont. (continued) to stay bent over going through ash tray picking out butts...told once again...needed to return to...room...cont. to be noncompliant (with) smoking policy..."</p>	F 280	<p>and will continue to review 24 hour reports and physician orders for needed care plan updates, and complete updates to care plans as indicated.</p> <p>How will the corrective action(s) be monitored to ensure the alleged deficient practice(s) will not reoccur; what quality assurance program will be put into place?</p> <p>1. The DON &/or ADON will review 3 care plans/week to monitor for compliance X 3 months and report the findings to the QA committee for 3 months, beginning in October.</p>	11/15/12	

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F 280	<p>Continued From page 17</p> <p>Medical record review of a daily skilled nurse's note dated April 18, 2012, revealed " ...Resident went outback outside. When nurse went to see what resident was doing (resident #53) had a lit cigarette. Resident instructed to throw away cig. Resident then came inside cussing at staff. Resident asked to give nurse lighter. Resident refused then was told administrator would be call. Resident then brought lighter up to nurses..."</p> <p>Review of the facility policy (undated) revealed, " ...The following smoking policy and agreement is designated to respect the rights and ensure the safety of our residents. This agreement will be explained to residents and/or responsible parties on admission and as needed...Facility will keep cigarettes and lighters for residents for whom supervised smoking has been deemed necessary. They will be kept in an area which is accessible to staff only...Smoking on the premises will be limited to the scheduled times and scheduled areas, unless the resident is accompanied by their responsible parties or visitors...Three episodes of non compliance to the smoking policy will result in suspension of smoking privileges for a specified time..."</p> <p>Observation on September 26, 2012, at 7:50 a.m., revealed resident #53 obtained a cigarette butt from the smokers ash bin outside in the smoking area. Continued observation revealed resident #53 smoking the cigarette. Continued observation revealed no staff present in the smoking area.</p> <p>Observation and interview on September 26, 2012, at 7:55 a.m., with the NHA and the DON,</p>	F 280			

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F 280	<p>Continued From page 18</p> <p>outside in the smoking area, revealed the DON had obtained a lighter from resident #53.</p> <p>Interview on September 26, 2012, at 11:40 a.m., in the hall, with Licensed Practical Nurse (LPN) #2, confirmed was not aware of all the residents who smoked.</p> <p>Interview on September 26, 2012, at 1:50 p.m., in the hall, with LPN #3, confirmed was not aware of all the residents who smoked.</p> <p>Interview on September 27, 2012, at 1:10 p.m., with the DON, in the conference room, confirmed no investigations had been completed to determine how resident #53 had obtained a lighter on April 18, 2012.</p> <p>Interview on September 27, 2012, at 1:55 p.m., with the NHA, in the conference room, confirmed the NHA was aware of resident #53's unsupervised smoking incident on February 17, 2012.</p> <p>Interview on October 1, 2012, at 10:30 a.m., at the nursing station, with the NHA, confirmed the NHA had a meeting with resident #53 when became aware of the resident smoking unsupervised on February 17, 2012, but had no documentation of the meeting.</p> <p>Interview on October 1, 2012, with the DON, in the hall confirmed the care plan dated August 10, 2012, had not been updated to include the resident's noncompliance with supervised smoking or that the resident had a lighter in their possession.</p>	F 280			

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F 280	<p>Continued From page 19</p> <p>Resident #9 was admitted to the facility on May 23, 2007, with diagnoses including Depressive Disorder, Traumatic Brain Injury, Convulsions, Urinary Incontinence, and Chronic Obstructive Pulmonary Disease.</p> <p>Medical record review of the Minimum Data Set (MDS) dated July 9, 2012, revealed the resident scored 13 out of 15 possible correct answers on the Brief Interview for Mental Status (BIMS - an assessment to determine cognitive abilities with a score of 13 to 15 indicating mild dementia). Continued review of the MDS revealed the resident required limited assistance of one with transfers and dressing, was capable of moving throughout the facility and eating at mealtime with supervision and set-up help only.</p> <p>Medical record review of the resident's Care Plan dated July 10, 2012, revealed, "...Potential for unsafe smoking...(name) is non-compliant with facility smoking policy at times...Goal: (name) will safely smoke at designated times, in designated areas with supervision of staff or family members/visitors...Current Approaches:...#4. Ensure (name) does not leave designated smoking area with smoking materials..."</p> <p>Review of the Quarterly Assessment for Smoking Safety dated July 10, 2012, revealed, "... resident smokes safely with minimal supervision, smoking apron, facility storage of tobacco products, assistance with lighting tobacco products, supervised smoking by staff..."</p> <p>Observation on September 26, 2012, at 11:00 a.m., 1:00 p.m., and 3:00 p.m., revealed the resident participated with the smoking group on</p>	F 280			

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F 280	<p>Continued From page 20 the patio outside the facility.</p> <p>Interview on September 26, 2012, at 10:00 a.m., with the Administrator, in the conference room, confirmed the facility had been made aware of the resident having possession of cigarettes this past weekend (September 22 and 23, 2012). Continued interview confirmed the Licensed Practical Nurse #4 (LPN) had called on Saturday (September 22, 2012) and left a message regarding resident #9 having personal possession of cigarettes. Continued interview confirmed the Administrator told LPN #4 to let the resident keep the cigarettes stating he/she thought the resident had been approved for independent smoking. Continued interview confirmed resident #9 should not have been allowed to keep cigarettes.</p> <p>Interview with the Director of Nursing in the DON's office September 26, 2012, at 3:30 p.m., confirmed the resident's care plan had not been revised to include the most recent episode of the resident's non-compliance with the smoking policy for not surrendering smoking materials before leaving the supervised area.</p> <p>Resident #34 was admitted to the facility on February 1, 2010, and readmitted on May 1, 2012, with diagnoses including Chronic Obstructive Pulmonary Disease, Hypertension, Congestive Heart Failure, Peripheral Vascular Disease, Anxiety, and Depressive Disorder.</p> <p>Medical record review of the quarterly Minimum Data Set dated September 13, 2012, revealed the resident scored 13 out of a possible 15 on the Brief Interview for Mental Status (BIMS - An</p>	F 280			

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F 280	<p>Continued From page 21</p> <p>assessment of cognitive abilities with a score of 13 to 15 indicating mild cognitive impairment.) Continued review revealed the resident could transfer self, ambulate in room, and motivate on and off the unit with supervision and set-up help only. Continued review revealed resident #34 refused care 4 to 6 days a week (but less than daily) that was necessary to achieve the resident's goals for health and well-being.</p> <p>Medical record review of the Social Service note dated September 15, 2011, revealed, "Resident had been outside smoking with another resident. When question how they light cigarettes, neither one had a lighter. This is not the first or second time the resident has had a verbal warning. Resident has been advised next time smoking rights will be taken away for three days per (facility) Smoking Policy. Will continue to monitor."</p> <p>Medical record review of the Social Service note dated June 12, 2012, revealed, "...Did room search for cigs(cigarettes) and lighters both was found in top drawer of...(resident #34) room. Talk to...(resident #34), told...we are not to have them in our rooms...said...would not do it again..."</p> <p>Medical record review of the resident's care plan dated September 13, 2012, revealed, "...Problem #13 Smoking: Supervised smoking with staff ...Goal #1...(resident #34) will safely smoke at designated times, in designated areas with supervision of staff or family members/visitors AEB (as evidenced by) no smoking injuries or incidents x (times) 90 days." Continued review of the resident's care plan revealed, "Current Approach(es)...#9 Assist...(resident #34) as</p>	F 280			

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F 280	<p>Continued From page 22</p> <p>needed to designated smoking area at designated times and supervise smoking. 10. Ensure...(resident #34) does not leave designated smoking area with smoking materials..." Continued review of the resident's care plan revealed a handwritten notation at the end of the "Current Approaches" dated June 18 (no year given), stating, "FYI (for your information) - Watch for hidden cigarettes, lighter in...(resident's) room, staff have suspected...(resident) slips outside on occasion & (and) has smoked."</p> <p>Medical record review of resident #34's Quarterly Assessment for Smoking Safety dated September 13, 2012, revealed, "...Smokes safely with minimal supervision. Smoking apron. Facility storage of tobacco products...Supervised smoking by staff...No change-continue smoking per policy."</p> <p>Review of the facility's Smoking Policy, revealed, "1. Resident's cigarettes will be kept at the nurse's station locked in the med room. 2. Resident's cigarettes will be labeled with the resident's name on each pack. 3. Residents will be allowed to smoke every two hours. Smoke times to be 9AM - 8PM. 4. No resident will be allowed to possess a cigarette lighter. 5. All residents will smoke in the designated area directly supervised. 6. Resident's will be allowed to go outside of building with family members to smoke at any time." Continued review of the Smoking Policy revealed the following disclaimer, "We at Brooke Wood Nursing Center elect to not differentiate between responsible and non-responsible residents. We feel that for the safety and fairness of the residents and our</p>	F 280			

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F 280	<p>Continued From page 23</p> <p>facility that this best suits this facility." Continued review revealed the Smoking Policy had been signed by resident #34 (no date noted).</p> <p>Observation on September 26, 2012, at 7:45 a.m., revealed resident #34 exited the building in a motorized chair through a door in the activities room, rode through the courtyard at the back of the building, and disappeared behind the corner at the end of the 100 hall. Observation outside the 100 hall exit door on September 26, 2012, at 7:46 a.m., revealed the resident seated on the motorized chair, smoking a cigarette. Continued observation revealed the resident proceeded back toward the courtyard where the resident was intercepted by the Administrator, and the Director of Nursing (DON).</p> <p>Interview with the Administrator on September 26, 2012, at 10:00 a.m., in the conference room confirmed the following; The facility was aware of some residents smoking unsupervised; Was not sure of the exact history of the problem, citing facility aware as recent as three months to a year ago; Had many conversations with ...(resident #34) regarding unsupervised smoking and keeping cigarettes and lighters in the resident's room; and Administrator was unsure if there were residents who could smoke unsupervised, citing believed some (referring to smokers) had in the past been allowed to smoke unsupervised.</p> <p>Interview on September 26, 2012, at 11:25 a.m., with staff person #1 confirmed knowledge resident #34 had been known to "every now and then, usually in the morning before breakfast" go out and smoke unsupervised.</p>	F 280			

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F 280	<p>Continued From page 24</p> <p>Interview on September 26, 2012, at 3:00 p.m., via telephone, with Licensed Practical Nurse #5 confirmed a package of cigarettes had been confiscated from resident #34 on September 22, 2012. Continued interview confirmed a room search on this date yielded additional cigarettes, and on September 23, 2012, the resident was again observed bringing cigarettes to the room.</p> <p>Interview with the Director of Nursing in the DON's office September 26, 2012, at 3:30 p.m., confirmed resident's care plan had not been revised to include the most recent episode of the resident's non-compliance with the smoking policy.</p> <p>Resident #58 was admitted to the facility on September 14, 2012, with diagnoses including Pneumonia, Chronic Airway Obstruction, Dementia with Behavior, Gouty Arthritis, Atrial Fibrillation, Hypertension, and Depressive Disorder.</p> <p>Review of the list of residents identified by the facility as smokers, revealed resident #58 participated in smoking activities during designated smoke breaks.</p> <p>Medical record review of the resident's care plan dated September 14, 2012, revealed no documentation the resident's smoking habits had been addressed on the care plan.</p> <p>Interview on September 26, 2012, at 1:57 p.m., with Licensed Practical Nurse (LPN) #3 at the nurse's station, confirmed resident #58 smoked during designated smoking breaks.</p>	F 280			

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F 280	<p>Continued From page 25</p> <p>Interview with the Director of Nursing (DON) in the DON's office on Sept. 26, 2012, at 2:15 p.m., confirmed the resident's smoking habits had not been addressed on the care plan.</p> <p>Resident #55 was admitted to the facility on February 15, 2012, with diagnoses including Dementia with Behaviors, Chronic Kidney Disease, Hypertension, Atrial Fibrillation, and Diabetes.</p> <p>Medical record review revealed the resident was sent to the local hospital on September 19, 2012 for evaluation. Continued review of the medical record revealed the resident was returned to the facility with a diagnosis of urinary tract infection and was to receive antibiotics for ten days.</p> <p>Medical record review of the care plan dated August 29, 2012, revealed the care plan did not address the resident having an urinary tract infection (UTI) and receiving antibiotics for ten days.</p> <p>Interview with the Assistant Director of Nursing and Minimum Data Set Coordinator on Sept 25, 2012, at 3:20 p.m., at the nurse's station, confirmed the care plan had not been updated to address the resident's UTI and receiving antibiotics for UTI.</p> <p>The Immediate Jeopardy was effective from September 22, 2012, through October 1, 2012, and was removed on October 1, 2012. An acceptable Allegation of Compliance, which removed the immediacy of the Jeopardy, was</p>	F 280		

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F 280	<p>Continued From page 26</p> <p>received and corrective actions were validated on-site by the survey team on October 1, 2012, through review of facility documents, staff and resident interviews, and observations. The survey team verified the allegation of compliance by:</p> <ol style="list-style-type: none"> 1. Verifying residents #81, #80, and #58 had been reassessed for smoking safety; and verifying the other residents who smoke at the facility had accurate smoking assessments. Accuracy of the smoking assessments was confirmed by the survey team through observation during smoking sessions. 2. Verifying residents #34, #53, #81, #80, #58 and #9 had been educated on the facility's revised smoking policy. The survey team verified the information on interview with resident #58 on September 26, 2012, at 4:00 p.m. The survey team verified the information with resident #53 through observation and interview on September 27, 2012, and interview with #80 on September 27, 2012, at 10:30 a.m. 3. Verifying the revision of the facility's smoking policy with acknowledgement of understanding and agreement to the policy by the residents to ensure a safe smoking environment for all residents. 4. Verification by the survey team on October 1, 2012, ensured by interviews with multidisciplinary staff, and review of inservice logs confirmed the staff received information regarding the facility's revised smoking policy including staff members are to ensure that all cigarettes and lighters are returned and locked up in the medication room, and that cigarette butts are collected and placed 	F 280			

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F 280	<p>Continued From page 27</p> <p>in the locked, metal containers following each smoke break. Residents who are found with cigarettes and/or lighters in their possession will be issued a 30 day discharge notice. Review of documentation confirmed the residents and families of the smoking residents were notified of the revised smoking policy.</p> <p>5. Verifying residents #53, #9, #34, and #58's care plans had been updated to reflect the safety needs for smoking.</p> <p>Interview with the Director of Nursing October 1, 2012, at 12:50 p.m., revealed members of the Quality Assurance committee (including the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Activity Director, Business Office Manager, Medical Records, Maintenance Supervisor, Certified Dietary Manager, and Housekeeping Supervisor) had met on September 28, 2012, to formulate a plan related to noncompliance with smoking and to develop a plan to ensure resident safety. Continued interview revealed the members of the Quality Assurance committee had revised the facility's Smoking Policy, and inserviced the residents and staff regarding the revised Smoking Policy. Continued interview revealed Social Services had contacted and mailed letters to the families of the residents who smoked, informing them of the facility's Smoking Policy. Continued interview revealed the facility's Medical Director had been made aware of the Immediate Jeopardy on September 28, 2012.</p> <p>Non compliance continues at an "E" level for monitoring corrective actions and evaluation by</p>	F 280			

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F 280	Continued From page 28 the facility's Quality Assessment and Assurance Committee. The facility is required to submit a plan of correction for all cited deficiencies.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow physician's orders to administer an increase in an antidepressant medication for one resident (#38) of forty-three residents reviewed. The findings included: Resident #38 was admitted to the facility on April 18, 2012, and readmitted on August 17, 2012, with diagnoses including Bibasilar Aspiration Pneumonia, Dementia, Senile Delusions, Hypertension, and Acute Bronchitis. Medical record review of a Behavioral Medicine Evaluation & Management Note dated August 22, 2012, revealed a recommendation to increase Lexapro (antidepressant) to 20 mg (milligrams) daily. Continued review of the Behavioral	F 309	F-309 Each resident receives and the facility provides the necessary care and services to attain and maintain the highest practical physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? 1. The MD was notified by the DON on 9/27/12, of the recommendation to increase resident #38's Lexapro to 20mg daily that was dated August 22, 2012. Order received and written to increase Lexapro to 20mg daily. How will you identify other residents having the potential to be affected by		

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F 280	Continued From page 28 the facility's Quality Assessment and Assurance Committee.		the same alleged practice(s) and what corrective action will be taken?		
F 309 SS=D	<p>The facility is required to submit a plan of correction for all cited deficiencies.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow physician's orders to administer an increase in an antidepressant medication for one resident (#38) of forty-three residents reviewed.</p> <p>The findings included:</p> <p>Resident #38 was admitted to the facility on April 18, 2012, and readmitted on August 17, 2012, with diagnoses including Bibasilar Aspiration Pneumonia, Dementia, Senile Delusions, Hypertension, and Acute Bronchitis.</p> <p>Medical record review of a Behavioral Medicine Evaluation & Management Note dated August 22, 2012, revealed a recommendation to increase Lexapro (antidepressant) to 20 mg (milligrams) daily. Continued review of the Behavioral</p>	F 309	<p>1. All current residents medical records were audited by the DON and ADON on 9/27/12, to verify no other resident's had received recommendations from the psychiatric consultant that had been filed without the orders being written. No other residents were found to have been affected.</p> <p>What measures will be put into place or what systematic changes will you make to ensure that the alleged deficient practice(s) does/do not reoccur?</p> <p>1. The Social Services Director will forward all psych. recommendations to the DON and/or ADON, who will review all psychiatric consultant recommendations as they are received and notify MD of recommendations and write new orders as indicated if</p>		

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F 309	Continued From page 29 Medicine Evaluation & Management Note revealed the physician had initialed the note. Medical record review of the August 23-31, 2012, and September 2012, Medication Record revealed the resident continued to receive Lexapro 10 mg daily. Observation on September 27, 2012, at 7:50 a.m., revealed the resident lying on the bed, sleeping with a scoop mattress and a tabs alarm in place. Interview and review of the Behavioral Medicine Evaluation & Management Note, on September 27, 2012, at 8:45 a.m., with the Director of Nursing, in the conference room, revealed when the physician initialed the Behavioral Medicine Evaluation & Management Note the recommendation for the Lexapro to be increased to 20 mg was approved and ordered. Continued interview confirmed the physician's order was not followed.	F 309	recommendations are approved by the MD. How will the corrective action(s) be monitored to ensure the alleged deficient practice(s) will not reoccur; what quality assurance program will be put into place? 1. DON and/or ADON will review all psychiatric consultant recommendations, MD response, and verify orders are written as indicated when recommendations are received from Psych. Services Consultants. Report of Psych. recommendations and response will be submitted to the QA committee for 3 months, beginning in October.	11/15/12	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to reposition and provide incontinence care for one resident (#27).	F 312	F-312 Resident's who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?		

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F 312	<p>Continued From page 30</p> <p>and failed to provide appropriately fitting attire for one resident (#3) of forty-three residents reviewed.</p> <p>The findings included:</p> <p>Resident #27 was admitted to the facility on May 28, 2008, with diagnoses including Dementia, Depressive Disorder, Constipation, Anemia, Generalized Anxiety, Hypertension, Osteoarthritis, and Esophageal Reflux.</p> <p>Medical record review of the quarterly Minimum Data Set dated July 27, 2012, revealed the resident had severely impaired cognitive skills, was always incontinent of bladder and bowel, and was totally dependent with two person assist for transfers and bed mobility.</p> <p>Observation on September 25, 2012, from 7:20 a.m., until 11:15 a.m., (3 hours and 55 minutes) revealed the resident seated in a geri-chair in the activity room with a table in front of the resident. Continued observation during this time revealed the resident fidgeting with the tablecloth and alternately lying the head on the table.</p> <p>Observation on September 25, 2012, at 11:15 a.m., revealed the resident seated in a geri-chair with the head resting on the table and the eyes closed.</p> <p>Observation on September 25, 2012, at 11:20 a.m., revealed the resident was transferred from the geri-chair to the bed. Continued observation revealed the resident had been incontinent of bladder and bowel. Continued observation revealed the top of the right thigh and the right buttock were reddened.</p>	F 312	<ol style="list-style-type: none"> 1. Resident #27 has not experienced any negative effects resulting from the delay in incontinence care being provided on 9/25/12. 2. Clothing for resident #3 has been checked for appropriate fit; Activity Director was notified of need for additional clothing on 9/26/12 and was obtained for resident #3. <p>How will you identify other residents having the potential to be affected by the same alleged practice(s) and what corrective action will be taken?</p> <ol style="list-style-type: none"> 1. The CNA for resident #27 was n in-serviced on 10/16/12 by the DON, on incontinence care and frequency of checking for incontinent episodes with all assigned residents. 2. The CNA assigned for resident #3 has been in-serviced by the DON on 10/16/12, on dressing residents in properly fitting clothing and notification to Charge Nurse, Social Services 		

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F 312	<p>Continued From page 31</p> <p>Interview on September 25, 2012, at 11:17 a.m., with Certified Nursing Assistant (CNA) #1, (CNA assigned to care for the resident), in the activity room, revealed the resident was placed in the geri-chair at approximately 6:50 a.m., and confirmed the resident had not been offered repositioning or incontinence care since 6:50 a.m.</p> <p>Interview on October 1, 2012, at 9:35 a.m., with the Director of Nursing, in the business office, revealed residents were to be repositioned and checked for incontinence every two hours, and confirmed three hours and fifty-five minutes was too long.</p> <p>Resident #3 was admitted to the facility on February 27, 2012, with diagnoses including Bipolar Disorder, Cognitive Disorder, Alcohol Abuse, Borderline Personality Disorder, Bells Palsy, Congestive Heart Failure, Chronic Back Pain, Tic Douloureux, and Gastroesophageal Reflux Disease.</p> <p>Medical record review of the quarterly Minimum Data Set (MDS) assessment dated August 11, 2012, revealed, the resident had short/long term memory problems, and severely impaired cognitive skills for daily decision making. Continued review revealed the resident was totally dependent on staff for transfers and dressing, was non-ambulatory and always incontinent of bladder and bowel.</p> <p>Review of the resident's Care Plan dated August 12, 2012, revealed, "...Problem #5: Resident is totally dependent for ADL's (activities of daily living) due to diagnosis of advanced dementia</p>	F 312	<p>Director, or Activity Director for residents clothing needs.</p> <p>3. Staff will be in-serviced by the DON, on 10/23/12 regarding incontinence care and residents clothing.</p> <p>What measures will be put into place or what systemic changes will you make to ensure the alleged deficient practice(s) does/do not reoccur?</p> <p>1. The Administrator, DON, ADON, and Activity Director will monitor for compliance with incontinence care and proper fitting clothing for residents 3 x week x 3 months by observation rounds; began on 10/15/12.</p> <p>How will the corrective action(s) be monitored to ensure the alleged deficient practice(s) will not reoccur; what quality assurance program will be put into place?</p> <p>1. Results of monitoring activity will be reported to the QA Committee monthly x 3 months, beginning in October.</p>	11/15/12	

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F 312	<p>Continued From page 32</p> <p>with confusion, osteoporosis, and psychosis...Goal #1: (resident's name) will have ADL needs met by staff as evidenced by clean, dry appropriate personal appearance with maintenance of dignity within the next 90 days.</p> <p>Observation on September 25, 2012, at 1:45 p.m., revealed resident #3 seated in the wheelchair in the hallway with the lap buddy in place. Continued observation revealed the resident appeared to be napping with eyes closed and the chin resting on the chest. Continued observation revealed the resident's blouse had a large neck opening and the neck of the blouse was hanging down the resident's right arm, off the shoulder, exposing a large area of bare skin.</p> <p>Interview at this time with LPN #2 confirmed the blouse did not fit properly, and the resident's shoulder should not be protruding through the opening in the neck. Continued observation revealed the resident was assisted back to the room and redressed with properly fitting clothing.</p>	F 312			
F 323 SS=K	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p>	F 323	<p>F-323-</p> <p>The facility ensures that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p>		

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F 323	<p>Continued From page 33</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to supervise smoking for six residents (#53, #34, #81, #80, #58, and #9) of nineteen residents identified as smokers of forty-three residents reviewed.</p> <p>The facility's failure placed resident #53, #34, #81, #80, #58, and #9 in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death) from unsafe smoking.</p> <p>The Nursing Home Administrator (NHA) and the Director of Nursing (DON) were notified of the Immediate Jeopardy on September 26, 2012, at 4:00 p.m., in the conference room.</p> <p>F 323 cited at a scope and severity level of "K" is substandard quality of care.</p> <p>The findings included:</p> <p>Resident #53 was admitted to the facility on August 20, 2010, with diagnoses including Dementia with Behaviors, Diabetes Mellitus, Depressive Disorder, and Hypertension.</p> <p>Medical record review of the Annual Minimum Data Set dated August 10, 2012, revealed the resident scored 15 out of 15 on the Brief Interview for Mental Status (BIMS-an assessment to determine cognitive abilities with a score of 13-15</p>	F 323	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <ol style="list-style-type: none"> 1. Residents #3 and #53 were immediately counseled (9/26/12) by DON and Administrator and eventually produced a partial cigarette (Resident #38) and a lighter (Resident 53). 2. The rooms and persons of Residents #38 and #53 were thoroughly searched, with their permission, 9/26/12 by the DON and ADON. 3. The rooms of all smokers after obtaining permission were thoroughly searched 9/26/12, by the Social Services Director. 4. A memo & in service to staff regarding discipline & responsibilities regarding the resident smoking policy and the fact that there are no unsupervised smokers in the facility was drafted and in service of staff begun 9/26/12, by the Administrator, DON, and ADON. 		

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F 323	<p>Continued From page 34</p> <p>indicating cognitively intact) and was independent with ambulation.</p> <p>Medical record review of the Quarterly Assessment for Smoking Safety dated August 10, 2012, revealed " ...Smokes safely with minimal supervision...Smoking apron...Facility storage of tobacco products...Assistance with lighting tobacco products...Supervised smoking by staff ..."</p> <p>Medical record review of the care plan dated August 10, 2012, revealed "...At risk for injury (related to) smoking status. (resident #53) requires supervision for safety with facility smoking policy..."</p> <p>Medical record review of a nurse's note dated February 17, 2012, revealed "... (2:40 a.m.) This nurse was on lunch in smoking area (with) a CNA (certified nursing assistant). Res. (resident) came out to smoke area and said, "will you do me a favor?" This nurse stated, "You know I can't permit you to smoke until it's your scheduled smoke time." ... This nurse (and) CNA returned into facility (and) res did not follow (and) was not visible. This nurse...went outside (and) observed res. digging in stand up ash bin ...had removed the top (and) was bent over smoking the cig's (cigarettes) that were put in there still lit. Res. was informed that it was unsanitary (and) ...needed to return to...(room)...Res. cont. (continued) to stay bent over going through ash tray picking out butts...told once again...needed to return to...room...cont. to be noncompliant (with) smoking policy..."</p> <p>Medical record review of a daily skilled nurse's</p>	F 323	<p>5. Resident smoking policy revised and in servicing of all staff began 9/26/12 and completed on 9/29/12, by the DON.</p> <p>6. Revised Resident smoking policy was given to social worker to be mailed to all family members 9/26/12 and will be included in admission packets as indicated.</p> <p>7. All family members of smokers were called by SSD and informed of the letter/policy they would be getting 9/28/12.</p> <p>8. Smokers info book created, by the DON, on 9/26/12 which includes the list of names of all smokers in the facility and a sign out sheet for the CNA who is taking residents out to smoke break to sign and the nurse who is checking the cigarettes, lighters back in to medication room to sign that all are accounted for.</p> <p>9. List of Smokers and smoking policy posted in break room, at nursing station and in Smokers info book 9/26/12, by the Administrator and DON.</p>		

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F 323	<p>Continued From page 35</p> <p>note dated April 18, 2012, revealed "...Resident went outback outside. When nurse went to see what resident was doing (resident #53) had a lit cigarette. Resident instructed to throw away cig. Resident then came inside cussing at staff. Resident asked to give nurse lighter. Resident refused then was told administrator would be call. Resident then brought lighter up to nurses..."</p> <p>Review of the facility policy (undated) revealed, "...The following smoking policy and agreement is designated to respect the rights and ensure the safety of our residents. This agreement will be explained to residents and/or responsible parties on admission and as needed...Facility will keep cigarettes and lighters for residents for whom supervised smoking has been deemed necessary. They will be kept in an area which is accessible to staff only...Smoking on the premises will be limited to the scheduled times and scheduled areas, unless the resident is accompanied by their responsible parties or visitors...Three episodes of non compliance to the smoking policy will result in suspension of smoking privileges for a specified time..."</p> <p>Observation on September 26, 2012, at 7:50 a.m., revealed resident #53 obtained a cigarette butt from the smokers ash bin outside in the smoking area. Continued observation revealed resident #53 smoking the cigarette. Continued observation revealed no staff present in the smoking area.</p> <p>Observation and interview on September 26, 2012, at 7:55 a.m., with the NHA and the DON, outside in the smoking area, revealed the DON had obtained a lighter from resident #53.</p>	F 323	<p>10. Meeting held with all smokers 9/26/12 to in service them on the revised smoking policy, by the Administrator and DON.</p> <p>11. All current smokers signed a copy of the smoking policy and acknowledged they knew the consequences of any violation of said policy 9/26/12.</p> <p>12. The charts of Residents #34 and #53 were audited for a smoking assessment on 9/26/12, by the MDS Coordinator.</p> <p>13. New smoking assessment done on all smokers in the building on 9/27/12 by the MDS Coordinator.</p> <p>14. Smoking perimeters being checked and monitored by staff every shift for violations in smoking policy. Additional perimeter checks on 11- 7 shift initiated 10.1.12</p> <p>15. Violation of smoking policy will result in 30 day discharge notice being issued.</p> <p>16. Violation of smoking policy will also result in the initiation of Q 15 minute checks on resident location & continued daily</p>		

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F 323	<p>Continued From page 36</p> <p>Interview on September 26, 2012, at 11:40 a.m., in the hall, with Licensed Practical Nurse (LPN) #2, confirmed LPN #2 was not aware of all the residents who smoked.</p> <p>Interview on September 26, 2012, at 1:50 p.m., in the hall, with LPN #3, confirmed LPN #3 was not aware of all the residents who smoked.</p> <p>Interview on September 27, 2012, at 1:10 p.m., with the DON, in the conference room, confirmed no investigations had been completed to determine how the resident had obtained a lighter on April 18, 2012.</p> <p>Interview on September 27, 2012, at 1:55 p.m., with the NHA, in the conference room, confirmed the NHA was aware of resident #53's unsupervised smoking on February 17, 2012.</p> <p>Interview on October 1, 2012, at 10:30 a.m., at the nursing station, with the NHA, confirmed the NHA had a meeting with resident #53 when became aware of the resident smoking unsupervised on February 17, 2012, but had no documentation of the meeting.</p> <p>Interview on October 1, 2012, with the DON, at 10:35 a.m., in the hall, confirmed the care plan dated August 10, 2012, had not been updated to include the resident's noncompliance with supervised smoking or the resident having a lighter in their possession.</p> <p>Resident #34 was admitted to the facility on February 1, 2010, and readmitted on May 1,</p>	F 323	<p>room searches for 30 days or until discharge, whichever comes first.</p> <p>How will you identify other residents having the potential to be affected by the same alleged practice(s) and what corrective action will be taken:</p> <ol style="list-style-type: none"> 1. Any resident has the potential to be affected by the same alleged deficient practice(s). 2. The rooms of all smokers were thoroughly searched 9/26/12. 3. A memo & in service to staff regarding discipline & responsibilities regarding the resident smoking policy and the fact that there are no unsupervised smokers in the facility was prepared and in service of staff begun 9/26/12, by the Administrator, DON, and ADON. 4. Resident smoking policy revised and in servicing of all staff began 9/26/12 and will be included with all new employee orientation. 5. Revised Resident smoking policy was given to social worker to be mailed to all 		

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F 323	<p>Continued From page 37</p> <p>2012, with diagnoses including Chronic Obstructive Pulmonary Disease, Hypertension, Congestive Heart Failure, Peripheral Vascular Disease, Anxiety, and Depressive Disorder.</p> <p>Medical record review of the Minimum Data Set dated September 26, 2012, revealed the resident scored 13 out of a possible 15 on the Brief Interview for Mental Status (BIMS - An assessment of cognitive abilities, 13-15 cognitively intact). Continued review revealed the resident could transfer self, ambulate in room, and motivate on and off the unit with supervision and set-up help only. Continued review revealed resident #34 refused care 4 to 6 days a week (but less than daily) that is necessary to achieve the resident's goals for health and well-being.</p> <p>Medical record review of the Social Service note dated September 15, 2011, revealed, "Resident had been outside smoking with another resident. When question how they light cigarettes, neither one had a lighter. This is not the first or second time the resident has had a verbal warning. Resident has been advised next time smoking rights will be taken away for three days per Brookwood Smoking Policy. Will continue to monitor."</p> <p>Medical record review of the Social Service note dated June 12, 2012, revealed, "...Did room search for cigs(cigarettes) and lighters both was found in top drawer of...(resident #34) room. Talk to...(resident #34), told...we are not to have them in our rooms...said...would not do it again..."</p> <p>Medical record review of the resident's care plan dated September 13, 2012, revealed, "Problem</p>	F 323	<p>family members 9/26/12.</p> <p>6. All family members of smokers were called by SSD and informed of the letter/policy they would be getting 9/28/12.</p> <p>7. Smokers information book created 9/26/12 by the DON.</p> <p>8. List of Smokers and smoking policy posted in break room, at nursing station and in Smokers info book 9/26/12, by the Administrator and DON.</p> <p>9. Meeting held with all smokers 9/26/12 to in service them on the revised smoking policy, by the Administrator, DON and Social Services Director.</p> <p>10. All current smokers signed a copy of the smoking policy and acknowledged they knew the consequences of any violation of said policy 9/26/12.</p> <p>11. The charts of Residents #34 and #53 were audited for a smoking assessment on 9/26/12 by the MDS Coordinator.</p> <p>12. New smoking assessment done on all smokers in the facility on 9/27/12 by the MDS Coordinator.</p>		

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F 323	<p>Continued From page 38</p> <p>#13 Smoking: Supervised smoking with staff...Goal #1...(resident #34) will safely smoke at designated times, in designated areas with supervision of staff or family members/visitors AEB (as evidenced by) no smoking injuries or incidents x (times) 90 days." Continued review of the resident's care plan revealed, "Current Approach(es)...#9 Assist...(resident #34) as needed to designated smoking area at designated times and supervise smoking. 10. Ensure...(resident #34) does not leave designated smoking area with smoking materials..." Continued review of the resident's care plan revealed a handwritten notation at the end of the "Current Approaches" dated June 18 (no year given), stating, "FYI (for your information) - Watch for hidden cigarettes, lighter in...(gender) room, staff have suspected...(gender) slips outside on occasion & (and) has smoked."</p> <p>Medical record review of resident #34's Quarterly Assessment for Smoking Safety dated September 13, 2012, revealed, "...Smokes safely with minimal supervision. Smoking apron. Facility storage of tobacco products...Supervised smoking by staff...No change-continue smoking per policy."</p> <p>Review of the facility's Smoking Policy, revealed, "1. Resident's cigarettes will be kept at the nurse's station locked in the med room. 2. Resident's cigarettes will be labeled with the resident's name on each pack. 3. Residents will be allowed to smoke every two hours. Smoke times to be 9AM - 8PM. 4. No resident will be allowed to possess a cigarette lighter. 5. All residents will smoke in the designated area</p>	F 323	<p>13. Smoking perimeters being checked and monitored by staff every shift for violations in smoking policy. Additional perimeter checks on 11- 7 shift initiated 10/1/12</p> <p>14. Violation of smoking policy will result in 30 day discharge notice being issued.sd</p> <p>15. Violation of smoking policy will also result in the initiation of Q 15 minute checks on resident's location and continued daily room searches for 30 days or discharge, whichever comes first.</p> <p>What measures will be put into place or what systematic changes will you make to ensure that the alleged deficient practice(s) does/do not reoccur:</p> <p>1. Smoking assessments will be completed by the admitting Charge Nurse on all new admission residents who smoke. Safe smoking interventions will be included on each new admission interim care plan for new admission residents who smoke.</p>		

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F 323	<p>Continued From page 39</p> <p>directly supervised. 6. Resident's will be allowed to go outside of building with family members to smoke at any time." Continued review of the Smoking Policy revealed the following disclaimer, "We at Brooke Wood Nursing Center elect to not differentiate between responsible and non-responsible residents. We feel that for the safety and fairness of the residents and our facility that this best suits this facility." Continued review revealed the Smoking Policy had been signed by resident #34 (no date noted).</p> <p>Observation on September 26, 2012, at 7:45 a.m., revealed resident #34 exited the building in a motorized chair through a door in the activities room, rode through the courtyard at the back of the building, and disappeared behind the corner at the end of the 100 hall. Continued observation revealed the resident seated on the motorized chair smoking a cigarette. Continued observation revealed the resident proceeded back toward the courtyard and was approached by the Administrator and Director of Nursing (DON).</p> <p>Interview with the DON on September 26, 2012, at 1:00 p.m., confirmed the facility's investigation revealed the resident had denied possessing smoking materials after the morning incident. Continued interview confirmed with the resident's permission, a half-smoked cigarette was removed from the resident's front shirt pocket, and a lighter was removed from the resident's left sock.</p> <p>Resident #34 declined to be interviewed.</p> <p>Interview with the Administrator on September 26, 2012, at 10:00 a.m., in the conference room</p>	F 323	<ol style="list-style-type: none"> 2. All smokers' rooms will be searched every day (beginning 9/26/12) for two weeks by social services, nursing, restorative & other administrative staff until they have gone 2 weeks without any smoking materials being discovered. 3. Upon completion of the daily-2 week rounds to smokers rooms and person, with permission, will be searched weekly by social services, nursing & other administrative staff for one month, then monthly as necessary. 4. Any resident who violates the policy and is found smoking unsupervised or with tobacco, lighters in their possession will be placed on q 15 minute checks and daily room checks. <p>How will the corrective action(s) be monitored to ensure the alleged deficient practice will not recur; what quality assurance program will be put into place?</p> <ol style="list-style-type: none"> 1. All smokers' rooms will be searched every day for two 		

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F 323	<p>Continued From page 40</p> <p>confirmed the following: The facility was aware of some residents smoking unsupervised; Was not sure of the exact history of the problem, citing facility aware as recent as three months to a year ago; Had many conversations with...(resident #34) regarding unsupervised smoking and keeping cigarettes and lighters in the resident's room; and Administrator was unsure if there were residents who could smoke unsupervised, citing believed some (referring to smokers) had in the past been allowed to smoke unsupervised.</p> <p>Resident #81 was admitted to the facility on September 12, 2012, with diagnoses including Right Hip Fracture, Urinary Tract Infection, Dementia, and Mild Hypertension.</p> <p>Medical record review of the Minimum Data Set dated September 19, 2012, revealed the resident scored 5 out of 15 possible correct answers on the Brief Interview for Mental Status assessment (BIMS - an assessment for cognitive functioning where a score of 1 to 7 indicates severe cognitive impairment.) Continued review revealed the resident requires extensive assistance with transfers, eating, and personal hygiene.</p> <p>Review of the list of residents identified by the facility as smokers revealed resident #81 was identified as a smoker</p> <p>Medical record review of the resident's Safe Smoking Evaluation (undated) revealed the evaluation was a two-sided assessment form, and the reverse side of the assessment had not been completed, leaving the final determination of the resident's ability to smoke safely unanswered.</p>	F 323	<p>weeks (beginning 9/26/12) by Social Services, nursing, Restorative nursing and other administrative staff until they have gone 2 weeks without any smoking materials being discovered.</p> <p>2. Upon completion of the daily 2 week rounds to smokers rooms and person, with permission, will be searched weekly by social services, nursing & other administrative staff for one month, then monthly as necessary.</p> <p>3. Administrative Staff, including the Administrator, Business office manager, Activity Director, Human Resources, and Nursing Supervisors, will monitor each smoke break for compliance with facility policies, daily beginning 10/26/12.</p> <p>4. Results of monitoring activities will be reviewed during Morning Meeting (Administrator, DON, ADON, SSD, MDS, Rehab, Housekeeping, Dietary, Maintenance, BOM, Activity Director) and reviewed by Risk (DON, ADON, SSD, MDS,</p>		

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F 323	<p>Continued From page 41</p> <p>Interview with the Assistant Director of Nursing (ADON) in the Director Of Nursing (DON) office on September 26, 2012, at 2:30 p.m., confirmed the Safe Smoking Evaluation in the medical record was not complete and did not identify the resident's ability to smoke safely.</p> <p>Resident #80 was admitted to the facility on August 23, 2012, with diagnoses including Urinary Tract Infection, Failure to Thrive, Muscle weakness, Abnormality of Gait, and Hypothyroidism.</p> <p>Medical record review of the admission Minimum Data Set dated August 30, 2012, revealed the resident scored 14 out of 15 possible correct answers on the BIMS assessment (a score of 13 to 15 indicates mild cognitive impairment). Continued review revealed the resident required extensive assistance with transfers, dressing, personal hygiene, and supervision with set-up help only at mealtime.</p> <p>Review of the list of residents identified by the facility as smokers, revealed resident #80 was an active smoker.</p> <p>Medical record review of the resident's smoking assessment titled, Safe Smoking Evaluation, dated August 13, 2012, revealed the evaluation was a two-sided assessment form, and the reverse side of the assessment had not been completed, leaving the final determination of the resident's ability to smoke safely unanswered.</p> <p>Interview with the Assistant Director of Nursing on</p>	F 323	Treatment Nurse, Dietary, Rehab, Restorative) and QA committees x 3 months, beginning in October.	11/15/12	

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F 323	<p>Continued From page 42</p> <p>September 26, 2012, at 2:30 p.m., in the DON's office, confirmed the resident had not been assessed for safe smoking per the current facility practice.</p> <p>Resident #58 was admitted to the facility on September 14, 2012, with diagnoses including Pneumonia, Chronic Airway Obstruction, Dementia with Behavior, Gouty Arthritis, Atrial Fibrillation, Hypertension, and Depressive Disorder.</p> <p>Review of the list of residents identified by the facility as smokers revealed resident #58 was an active smoker.</p> <p>Medical record review of the resident's assessments revealed no documentation the resident had been assessed for safe smoking.</p> <p>Interview on September 26, 2012, at 1:57 p.m., with Licensed Practical Nurse (LPN) #3 at the nurse's station, confirmed resident #58 smoked during designated smoking breaks.</p> <p>Interview with the Director Of Nursing (DON) in the DON's office on Sept. 26, 2012, at 2:15 p.m., confirmed resident #58 had not been assessed for safe smoking. Continued interview confirmed Social Services was responsible for alerting nursing staff to the residents smoking preference, and the nursing assessment should have been completed by the nurse who completes the admission assessment.</p> <p>Resident #9 was admitted on May 23, 2007, with diagnoses including Depressive Disorder,</p>	F 323			

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F 323	<p>Continued From page 43</p> <p>Traumatic Brain Injury, Convulsions, Urinary Incontinence, Gastroesophageal Reflux Disease and Chronic Obstructive Pulmonary Disease.</p> <p>Medical record review of the Minimum Data Set dated July 9, 2012, revealed the resident scored 13 out of 15 possible correct answers on the BIMS assessment with 13 to 15 being mild cognitive impairment. Continued review revealed the resident required limited assistance for transfers and dressing, and supervision for locomotion on the unit, and eating.</p> <p>Medical record review of the resident's Care Plan dated July 10, 2012, revealed, "...Potential for unsafe smoking (resident's name) is non-compliant with facility smoking policy at times ...Goal: (resident's name) will safely smoke at designated times, in designated areas with supervision of staff or family members/visitors...Current Approaches...#4. Ensure (resident's name) does not leave designated smoking area with smoking materials..."</p> <p>Medical record review of the Quarterly Assessment for Smoking Safety dated July 10, 2012, revealed, the resident smokes safely with minimal supervision, uses a smoking apron, facility storage of tobacco products, assistance with lighting tobacco products, and is supervised during smoking by staff...</p> <p>Observation on September 26, 2012, at 11:00 a.m., 1:00 p.m., and 3:00 p.m., revealed the resident participated in smoking with the group outside during each of these smoke breaks.</p>	F 323			

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F 323	<p>Continued From page 44</p> <p>Interview on September 26, 2012, at 10:00 a.m., with the Administrator, in the conference room, confirmed the facility had been made aware of the resident having possession of cigarettes this past weekend (September 22 and 23, 2012). Continued interview confirmed the Licensed Practical Nurse #4 (LPN) had called on Saturday (September 22, 2012) and left a message regarding resident #9 having personal possession of cigarettes. Continued interview confirmed the Administrator told LPN #4 to let the resident keep the cigarettes stating he/she thought the resident had been approved for independent smoking. Continued interview confirmed resident #9 should not have been allowed to keep cigarettes.</p> <p>Interview on September 26, 2012, at 11:30 a.m., with staff person #1 on the 200 hall, confirmed knowledge of some residents going out before breakfast to smoke without supervision. Continued interview confirmed staff person #1 named residents #9, #53, and #34 as among the group of non-compliant smokers.</p> <p>Interview with Certified Nurse Aide (CNA) #5 on September 26, 2012, at 2:45 p.m. on the 100 hallway, confirmed had no personal knowledge of non-compliant smokers, but had been instructed by seasoned staff to keep an eye on residents #9, #53, and #34 for unsupervised smoking.</p> <p>The Immediate Jeopardy was effective from September 22, 2012, through October 1, 2012, and was removed on October 1, 2012. An acceptable Allegation of Compliance, which removed the immediacy of the Jeopardy, was received and corrective actions were validated on-site by the survey team on October 1, 2012.</p>	F 323			

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F 323	<p>Continued From page 45</p> <p>through review of facility documents, staff and resident interviews, and observations. The survey team verified the allegation of compliance by:</p> <ol style="list-style-type: none"> 1. Verifying residents #81, #80, and #58 had been reassessed for smoking safety; and verifying the other residents who smoke at the facility had accurate smoking assessments. Accuracy of the smoking assessments was confirmed by the survey team through observation during smoking sessions. 2. Verifying residents #34, #58, #81, #80, #58 and #9 had been educated on the facility's revised smoking policy. The survey team verified the information on interview with resident #58 on September 26, 2012, at 4:00 p.m. The survey team verified the information with resident #53 through observation and interview on September 27, 2012, and interview with #80 on September 27, 2012, at 10:30 a.m. 3. Verifying the revision of the facility's smoking policy with acknowledgement of understanding and agreement to the policy by the residents to ensure a safe smoking environment for all residents. 4. Verification by the survey team on October 1, 2012, ensured by interviews with multidisciplinary staff, and review of inservice logs confirmed the staff received information regarding the facility's revised smoking policy including staff members are to ensure that all cigarettes and lighters are returned and locked up in the medication room, and that cigarette butts are collected and placed in the locked, metal containers following each smoke break. Residents who are found with 	F 323			

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F 323	<p>Continued From page 46</p> <p>cigarettes and/or lighters in their possession will be issued a 30 day discharge notice. Review of documentation confirmed the residents and families of the smoking residents were notified of the revised smoking policy.</p> <p>5. Verifying residents #53, #9, #34, and #58's care plans had been updated to reflect the safety needs for smoking.</p> <p>Interview with the Director of Nursing October 1, 2012, at 12:50 p.m., revealed members of the Quality Assurance committee (including the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Activity Director, Business Office Manager, Medical Records, Maintenance Supervisor, Certified Dietary Manager, and Housekeeping Supervisor) had met on September 28, 2012, to formulate a plan related to noncompliance with smoking and to develop a plan to ensure resident safety. Continued interview revealed the members of the Quality Assurance committee had revised the facility's Smoking Policy, and inserviced the residents and staff regarding the revised Smoking Policy. Continued interview revealed Social Services had contacted and mailed letters to the families of the residents who smoked, informing them of the facility's Smoking Policy. Continued interview revealed the facility's Medical Director had been made aware of the Immediate Jeopardy on September 28, 2012.</p> <p>Non compliance continues at an "E" level for monitoring corrective actions and evaluation by the facility's Quality Assessment and Assurance Committee.</p>	F 323			

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F 323	Continued From page 47	F 323			
F 333 SS=D	<p>The facility is required to submit a plan of correction for all cited deficiencies</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview the facility failed to administer insulin in a timely manner for one resident (#56) of ten resident medication observations.</p> <p>The findings included:</p> <p>Resident #56 was readmitted to the facility on September 20, 2012, with diagnoses including Atrial Fibrillation, Diabetes, Hypertension, Dementia, Psychosis, and Depression.</p> <p>Medical record review of the physician's recapitulation orders dated September 2012, revealed the resident was to receive Lantus (insulin) 5 units at 7:00 a.m.</p> <p>Review of the facility's policy Administering Medications revealed "...9. Medications may not be prepared in advance and must be administered with one (1) hour of their prescribed time..."</p> <p>Observation of a medication pass on September 24, 2012, at 9:20 a.m., revealed Licensed</p>	F 333	<p>F 333</p> <p>The facility will ensure that resident's are free of significant medication errors.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <p>1. MD notified of resident #56 receiving AM insulin late on 9/24/12, by the Charge Nurse with no noted side effects. No new orders were received.</p> <p>How will you identify other residents having the potential to be affected by the same alleged practice(s) and what corrective action will be taken?</p> <p>1. Charge Nurse #2 completed medication error report and reported medication error to MD. Charge Nurse received training regarding medication administration on 10/12/12 by the DON.</p>		

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F 323	Continued From page 47	F 323	What measures will be put into place or what systematic changes will you make to ensure that the alleged deficient practice(s) does/do not reoccur?		
F 333 SS=D	<p>The facility is required to submit a plan of correction for all cited deficiencies</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview the facility failed to administer insulin in a timely manner for one resident (#56) of ten resident medication observations.</p> <p>The findings included:</p> <p>Resident #56 was readmitted to the facility on September 20, 2012, with diagnoses including Atrial Fibrillation, Diabetes, Hypertension, Dementia, Psychosis, and Depression.</p> <p>Medical record review of the physician's recapitulation orders dated September 2012, revealed the resident was to receive Lantus (insulin) 5 units at 7:00 a.m.</p> <p>Review of the facility's policy Administering Medications revealed "...9. Medications may not be prepared in advance and must be administered with one (1) hour of their prescribed time..."</p> <p>Observation of a medication pass on September 24, 2012, at 9:20 a.m., revealed Licensed</p>	F 333	<p>1. In-service for licensed nursing staff on 10/23/12 by the DON for medication administration policy, timely delivery of medications, medication errors will be done by DON and ADON.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur; what quality assurance program will be put into place?</p> <p>1. DON, ADON, and/or Consultant Pharmacist will conduct medication pass observations monthly with licensed nurses to monitor for compliance. Staff education and/or disciplinary action as indicated for non- compliance with medication administration procedures. Results of medication pass observations and medication error reports will be reported to the QA Committee monthly x 3 months, beginning in October.</p>		

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F 333	Continued From page 48 Practical Nurse (LPN) #2 administered Lantus insulin 5 units to the resident. Interview with LPN #2 on September 24, 2012, at 10:37 a.m., at the nurses' station, confirmed the Lantus (insulin) was administered past the prescribed time (2 hours 20 minutes late). Interview with the Assistant Director of Nursing on September 27, 2012, at 10:45 a.m., in the Director of Nursing's office, confirmed the insulin was given past the prescribed time and confirmed the insulin was to be given within one hour of the prescribed time.	F 333			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441	F 441 The facility has established and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? 1. CNA #1 has received training by the DON on 10/16/12, regarding infection control and hand washing policy.		

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F 441	<p>Continued From page 49</p> <p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to ensure staff washed the hands after providing incontinence care for one resident (#27) of forty-three residents reviewed.</p> <p>The findings included:</p> <p>Observation on September 25, 2012, at 11:20 a.m., revealed resident #27 was transferred from the geri-chair to the bed. Continued observation revealed the resident had been incontinent of bladder and bowel, and Certified Nursing Assistant (CNA) #1 provided incontinence care to the resident. Continued observation revealed after providing incontinence care, CNA #1 removed the gloves and without washing the hands, exited the room and obtained clean linens</p>	F 441	<p>How will you identify other residents having the potential to be affected by the same alleged practice(s) and what corrective action will be taken?</p> <p>1. CNA's and licensed nurses will be in-serviced on hand washing policy on 10/23/12 by the DON.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice(s) does/do not reoccur?</p> <p>1. DON, ADON, Charge Nurses, will monitor for compliance with hand washing following incontinence care by observation of CNA's providing incontinence care to our residents 3 times per week for 3 months, beginning 10/26/12.</p> <p>How will the corrective action(s) be monitored to ensure the alleged deficient practice will not reoccur; what quality assurance program will be put into place?</p> <p>1. Results of the monitoring and compliance will be tracked by</p>		

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F 441	Continued From page 50 from the clean linen supply. Review of the facility's policy Hand Washing revealed "It is the policy of this facility that hand washing be regarded as the single most important means of preventing the spread of infections...Appropriate...hand washing must be performed under the following conditions...after offering incontinence care...after contact with blood, urine, feces, oral secretions...the use of gloves did not replace hand washing..."	F 441	the ADON and reported to the QA committee monthly for 3 months, beginning in November.	11/15/12	
F 490 SS=K	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to be administered in a manner to ensure an effective system was in place to assess, careplan and supervise residents (#34, #53, #81, #80, #58, and #9) for safe smoking. The facility's failure to ensure safe smoking practices was likely to cause serious injury, harm, impairment or death to residents #34, #53, #81, #80, #58, and	F 490	F 490 The facility is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well- being of each resident. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? 1. Smoking Assessments and care plans for resident's #34, #53, #81, #80, #58, and #9 were reviewed by the MDS		

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F 490	<p>Continued From page 51</p> <p>#9 and potentially for all residents who smoke.</p> <p>The findings included:</p> <p>Interview on September 26, 2012, at 10:00 a.m., with the Administrator, in the conference room, confirmed the facility had been made aware of the resident having possession of cigarettes this past weekend (September 22 and 23, 2012). Continued interview confirmed the Licensed Practical Nurse #4 (LPN) had called on Saturday (September 22, 2012) and left a message regarding resident #9 having personal possession of cigarettes. Continued interview confirmed the Administrator told LPN #4 to let the resident keep the cigarettes stating he/she thought the resident had been approved for independent smoking. Continued interview confirmed resident #9 should not have been allowed to keep cigarettes.</p> <p>Refer to F272 for failure to complete smoking assessments.</p> <p>Refer to F280 for failure to update care plans to reflect interventions for residents' safe smoking.</p> <p>Refer to F323 for failure to supervise and follow the facility's policy to ensure safe smoking.</p> <p>The Nursing Home Administrator and Director of Nursing were notified of the Immediate Jeopardy on September 26, 2012, at 4:00 p.m., in the conference room.</p> <p>The Immediate Jeopardy was effective from September 22, 2012, through October 1, 2012, and was removed on October 1, 2012. An acceptable Allegation of Compliance, which</p>	F 490	<p>Coordinator and revised as indicated on 9/27/12.</p> <p>2. The Regional Vice President over Operations had input into formulating the POC and will be on site to review the implementation of the POC by November 2012.</p> <p>How will you identify other residents having the potential to be affected by the same alleged practice(s) and what corrective action will be taken?</p> <p>1. Smoking assessments and care plans were reviewed, by the MDS Coordinator, DON and ADON, and revised as indicated for all residents that smoke at the facility, by 9/29/12. New admission care plans will be reviewed and revised as indicated.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice(s) does/do not recur?</p> <p>1. The QA Committee met on 9/26/12 to review the facility smoking policy and practices</p>		

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F 490	<p>Continued From page 52</p> <p>removed the immediacy of the Jeopardy, was received and corrective actions were validated on-site by the survey team on October 1, 2012, through review of facility documents, staff and resident interviews, and observations. The survey team verified the allegation of compliance by:</p> <ol style="list-style-type: none"> 1. Verifying residents #81, #80, and #58 had been reassessed for smoking safety; and verifying the other residents who smoke at the facility had accurate smoking assessments. Accuracy of the smoking assessments was confirmed by the survey team through observation during smoking sessions. 2. Verifying residents #34, #53, #81, #80, #58 and #9 had been educated on the facility's revised smoking policy. The survey team verified the information on interview with resident #58 on September 26, 2012, at 4:00 p.m. The survey team verified the information with resident #53 through observation and interview on September 27, 2012, and interview with #80 on September 27, 2012, at 10:30 a.m. 3. Verifying the revision of the facility's smoking policy with acknowledgement of understanding and agreement to the policy by the residents to ensure a safe smoking environment for all residents. 4. Verification by the survey team on October 1, 2012, ensured by interviews with multidisciplinary staff, and review of inservice logs confirmed the staff received information regarding the facility's revised smoking policy including staff members are to ensure that all cigarettes and lighters are returned and locked up in the medication room, 	F 490	<p>and developed an action plan to ensure the safety of all resident's.</p> <ol style="list-style-type: none"> 2. The Smoking Policy was revised and reviewed with all residents at the facility who smoke by the Administrator and DON on 9/26/12. All of these residents acknowledged understanding of the revised smoking policy and agreed to comply with the revised smoking policy to ensure the safety of all residents. Notification was made to all family members of residents who smoke, by letter and phone calls by the Social Services Director on 9/27/12. 3. All Staff members at the facility were in-serviced on the revised Resident Smoking Policy and Facility Protocol for Resident Smoking and ensuring that all cigarettes and lighters were locked up in the medication room and all cigarette butts were collected following each smoke break. Staff in-service 		

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F 490	<p>Continued From page 53</p> <p>and that cigarette butts are collected and placed in the locked, metal containers following each smoke break. Residents who are found with cigarettes and/or lighters in their possession will be issued a 30 day discharge notice. Review of documentation confirmed the residents and families of the smoking residents were notified of the revised smoking policy.</p> <p>5. Verifying residents #53, #9, #34, and #58's care-plans had been updated to reflect the safety needs for smoking.</p> <p>Interview with the Director of Nursing October 1, 2012, at 12:50 p.m., revealed members of the Quality Assurance committee (including the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Activity Director, Business Office Manager, Medical Records, Maintenance Supervisor, Certified Dietary Manager, and Housekeeping Supervisor) had met on September 28, 2012, to formulate a plan related to noncompliance with smoking and to develop a plan to ensure resident safety. Continued interview revealed the members of the Quality Assurance committee had revised the facility's Smoking Policy, and inserviced the residents and staff regarding the revised Smoking Policy. Continued interview revealed Social Services had contacted and mailed letters to the families of the residents who smoked, informing them of the facility's Smoking Policy. Continued interview revealed the facility's Medical Director had been made aware of the Immediate Jeopardy on September 28, 2012.</p> <p>Non compliance continues at an "E" level for</p>	F 490	<p>was completed on 10/01/12, by the Administrator, DON and ADON.</p> <p>4. A monitoring system to ensure compliance with the Smoking Policy was put in place on 9/26/12, to ensure compliance with safe smoking practices. Facility staff and Licensed Nurses will ensure that all cigarettes and lighters are returned to be locked up following each smoke break. Facility staff will ensure that all cigarette butts are collected and placed in locked, metal containers. The Social Services Director or designed will perform room searches for contraband as indicated by the facility policy.</p> <p>How will the corrective action(s) be monitored to ensure the alleged deficient practice(s) will not reoccur; what quality assurance program will be put into place?</p> <p>1. Results of the monitoring system audits will be reviewed by the QA Committee monthly x 3 months, beginning in October.</p>	11/15/12	

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F 490	Continued From page 54 monitoring corrective actions and evaluation by the facility's Quality Assessment and Assurance Committee.	F 490			
F 497 SS=E	<p>The facility is required to submit a plan of correction for all cited deficiencies.</p> <p>483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE</p> <p>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of nurse aide in-service hours and interview, the facility failed to ensure the nurse aides had 12 hours of inservice education per year for six of twenty-three nurse aides reviewed.</p> <p>The findings included:</p> <p>Review of the nurse aide inservice education documentation revealed six of the twenty-three nurse aides employed by the facility had not</p>	F 497	<p>F 497</p> <p>The facility completes annual performance reviews for all nursing assistants and provides in-service education based on the outcome of performance reviews and needs of the resident's.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <ol style="list-style-type: none"> 1. Review of CNA hire dates, by the ADON, for annual performance reviews and in-service education revealed 5 of the 6 CNA's with insufficient in-service hours had incorrect hire dates listed on the in-service records; only 1 of the CNA's had actually failed to complete the required annual in- service training hours. This CNA had 10.25 in-service training hours with 1.45 hours needed by 		

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F 490	Continued From page 54 monitoring corrective actions and evaluation by the facility's Quality Assessment and Assurance Committee. The facility is required to submit a plan of correction for all cited deficiencies.		10/1/2012. This CNA has completed the remainder of her in-service education hours on 10/11/12.		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on review of nurse aide in-service hours and interview, the facility failed to ensure the nurse aides had 12 hours of inservice education per year for six of twenty-three nurse aides reviewed. The findings included: Review of the nurse aide inservice education documentation revealed six of the twenty-three nurse aides employed by the facility had not	F 497	How will you identify other employees having the potential to be affected by the same alleged practice(s) and what corrective action will be taken? 1. The ADON reviewed all CNA in- service records, on 9/29/12, and corrected hire date/annual review date for previous incorrect in-service training records for the CNA's. A log of all CNA's was compiled listing current hours that were needed by the next performance review and the date by which the in- service hours must be completed. The CNA's were instructed during the in-service on 10/8/12 by the DON, regarding the in-service education requirements. The in- service hours log was posted in the employee break-room. What measures will be put into place or what systemic changes will you make to		

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F 490	Continued From page 54 monitoring corrective actions and evaluation by the facility's Quality Assessment and Assurance Committee.		ensure that the alleged deficient practice(s) does/do not reoccur?		
F 497 SS=E	The facility is required to submit a plan of correction for all cited deficiencies. 483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12- months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on review of nurse aide in-service hours and interview, the facility failed to ensure the nurse aides had 12 hours of inservice education per year for six of twenty-three nurse aides reviewed. The findings included: Review of the nurse aide inservice education documentation revealed six of the twenty-three nurse aides employed by the facility had not	F 497	1. An Annual In-Service calendar was posted in the employee break-room on 10/01/12 by the ADON. ADON will check at the beginning of each month for Annual Performance Evaluations due in the month and review with CNA In-Service records to ensure required in- service hours have been completed prior to Annual Performance review date. In- service training hours will be calculated annually by date of hire. How will the corrective action(s) be monitored to ensure the alleged deficient practice will not reoccur; what quality assurance program will be put into place? 1. ADON will monitor for completion of required in- service education hours, each month, beginning in October, prior to completion of the annual performance review and		

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F 497	Continued From page 55 received the required 12 hours per year. Interview with the Assistant Director of Nursing on October 1, 2012, at 3:00 p.m., in the conference room, confirmed the six nurse aides had not received the 12 hours of the required inservice education per year.	F 497	will report the results to the QA Committee for 3 months, beginning in October. 10/24/12 POC date 11/15/12 Mary Ann Byrne RN PHIL-II	11/30/12 11/15/12	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to obtain lab work timely for one resident (#69) of forty-three residents reviewed. The findings included: Resident #69 was admitted to facility on October 8, 2010, and readmitted on February 13, 2012, with diagnoses including End Stage Renal Disease, Convulsions, Hypertension, Gastroesophageal Reflux Disease, Peripheral Vascular Disease, Dementia without Behaviors, Depressive Disorder, Diabetes, and Hypothyroidism. Review of the Physician's Orders dated September 1, 2012, revealed, Levothyroxine	F 502	The facility provides and obtains laboratory services to meet the needs of its residents. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? 1. The medical record for resident #69 was reviewed to ensure all needed labs were ordered to be obtained as indicated by routine lab and MD orders, by the ADON on 9/27/12. How will you identify other residents having the potential to be affected by the same alleged practice(s) and what corrective action will be taken? 1. The medical records for all current residents were audited to ensure orders were in place for all routine lab orders by the		

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F 502	Continued From page 56 Sodium (thyroid medication) 25 mcg (microgram) tablet 1 by mouth every day. Review of the facility's policy for Routine Lab Orders revealed the following: "Routine lab work will be ordered on residents at admission, and as indicated following admission based on the types of medications prescribed. Each resident's lab orders will be printed on the Physician Order Sheet. All lab work will be ordered as per routine facility lab orders, unless otherwise ordered by the Physician ..." Medical record review of the resident's standing orders (undated) signed by the physician, revealed, TSH (Thyroid Stimulating Hormone) q (every) 6 months. Continued medical record review revealed the most recent TSH was completed on February 21, 2012 (a seven month span). Interview with the Assistant Director Of Nursing in the conference room on October 1, 2012, at 10:49 a.m., confirmed the lab obtained in April 2012, was in addition to the TSH labs due every 6 months, and the TSH due in April had not been obtained.	F 502	ADON and completed on 10/23/12. What measures will be put into place or what systematic changes will you make to ensure that the alleged deficient practice(s) does/do not reoccur? 1. The ADON will maintain a tracking log for all routine lab orders to ensure labs are obtained as ordered. The ADON will review orders each morning and add new orders to the lab log as orders are received from the MD. How will the corrective action(s) be monitored to ensure the alleged deficient practice will not reoccur; what quality assurance program will be put into place? 1. The ADON will monitor lab orders for achievement weekly and will report on the completion of routine lab orders to the QA Committee monthly x 3 months, beginning in October.	11/15/12	
F 514 SS=D	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514	F 514 The facility maintains clinical records on each resident in accordance with accepted professional standards and		

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F 514	<p>Continued From page 57</p> <p>standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain a complete medical record for two residents (#38, and #17) of forty-three residents reviewed.</p> <p>The findings included:</p> <p>Medical record review of a Diet Requisition dated April 18, 2012, revealed resident #38 was to receive Boost (nutritional supplement) twice daily.</p> <p>Medical record review revealed no documentation resident #38 received Boost (nutritional supplement).</p> <p>Interview of September 27, 2012, at 9:50 a.m., with the Certified Dietary Manager revealed the resident had received Boost twice daily since admission to the facility.</p> <p>Interview on September 27, 2012, at 12:30 p.m., with the Director of Nursing (DON), in the DON's office, confirmed there was no documentation the resident had received the Boost.</p>	F 514	<p>practices that are complete, accurately documented, readily accessible, and systematically organized.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <ol style="list-style-type: none"> 1. Resident #38 receives Boost twice daily with her meals. Boost consumption was documented with the rest of her meals and not as a separate supplement. 2. Resident #17 failed to have Geodon documented as given for the evening dose. Nursing Staff were in-serviced on 10/23/12 by the DON on accurate documentation of supplement intake. <p>How will you identify other residents having the potential to be affected by the same alleged practice(s) and what corrective action will be taken?</p> <ol style="list-style-type: none"> 1. The CDM has reviewed nutritional supplements for all residents and provided the DON and ADON with a listing of all 		

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F 514	<p>Continued From page 57</p> <p>standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain a complete medical record for two residents (#38, and #17) of forty-three residents reviewed.</p> <p>The findings included:</p> <p>Medical record review of a Diet Requisition dated April 18, 2012, revealed resident #38 was to receive Boost (nutritional supplement) twice daily.</p> <p>Medical record review revealed no documentation resident #38 received Boost (nutritional supplement).</p> <p>Interview of September 27, 2012, at 9:50 a.m., with the Certified Dietary Manager revealed the resident had received Boost twice daily since admission to the facility.</p> <p>Interview on September 27, 2012, at 12:30 p.m., with the Director of Nursing (DON), in the DON's office, confirmed there was no documentation the resident had received the Boost.</p>	F 514	<p>residents who have orders to receive nutritional supplements. All residents who receive nutritional supplements will have these documented separately beginning in the month of November on the CNA ADL tracking form.</p> <p>2. Nutritional supplements will be documented separately from meal consumption to adequately monitor intake of supplements. All staff to be in-service on this procedure on 10/23/12 by the DON.</p> <p>3. Nursing staff will receive in-service training on 10/23/12 by the DON, on complete and accurate documentation on the CNA- ADL Tracking Form.</p> <p>What measures will be put into place or what systematic changes will you make to ensure that the alleged deficient practice(s) does/do not reoccur?</p> <p>1. DON or ADON will monitor for accurate documentation of nutritional supplements and medication administration for 10 residents weekly x 1 month, then bi-weekly x 2 months beginning in November.</p>		

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F 514	Continued From page 58 Medical record review of the August 2012, physician's orders, for resident #17, revealed the resident was to receive Geodon (antipsychotic medication) 60 mg (milligrams) every evening. Medical record review of the August 2012, Medication Administration Record revealed no documentation the resident had received the Geodon for August 1-30, 2012. Interview on September 25, 2012, at 3:22 p.m., with Licensed Practical Nurse #1 (LPN), at the nursing station, revealed LPN #1 worked at the facility full time (five of seven days weekly) and had administered the Geodon 60 mg in the evenings in August 2012. Continued interview confirmed there was no documentation the Geodon 60 mg was administered in the evenings in August 2012.	F 514	How will the corrective actions be monitored to ensure the deficient practice will no recur; what quality assurance program will be put into place? 1. Results of monitoring will be reported to the QA Committee monthly x 3 months beginning in November, by the DON and/or ADON.	11/15/12	
F 520 SS=K	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520	F 520 The facility maintains a Quality Assessment and Assurance Committee that meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develop and implements appropriate plans of action to correct identified quality deficiencies. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?		

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F 520	<p>Continued From page 59</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on facility interviews the facility failed to ensure the Quality Assurance Committee identified areas of improvement and implemented a plan to address safety with smoking for six residents (#53, #34, #81, #80, #58, and #9) of nineteen residents identified as smokers.</p> <p>The facility's failure to address residents' safety by reviewing data to assist in formulating improvement plans (for individual residents and for resident who smoked) placed residents (#53, #34, #81, #80, #58, and #9) in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious harm, injury, impairment or death).</p> <p>The Nursing Home Administrator (NHA) and the Director of Nursing (DON) were notified of the Immediate Jeopardy on September 26, 2012, at 4:00 p.m., in the conference room.</p> <p>The findings included:</p> <p>Interview on September 26, 2012, at 10:00 a.m.,</p>	F 520	<p>1. The QA Committee met on 9/26/12 to review the facility policy and practices for residents #53, #34, #81, #58, and #9, and all other residents who smoke at the facility.</p> <p>How will you identify other residents having the potential to be affected by the same alleged practice(s) and what corrective action will be taken?</p> <p>1. The facility implemented a revised smoking policy and additional measures to ensure safe smoking practices-locking up all cigarettes and lighters in the medication room, collecting cigarette butts following resident smoke breaks.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice(s) does/do not reoccur.</p> <p>1. CNAs, Charge Nurses will monitor for compliance with implemented safe smoking practices by signing cigarettes and lighters in following each</p>		

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F 520	<p>Continued From page 60</p> <p>with the Administrator, in the conference room, confirmed the facility had been made aware of the resident having possession of cigarettes this past weekend (September 22 and 23, 2012). Continued interview confirmed the Licensed Practical Nurse #4 (LPN) had called on Saturday (September 22, 2012) and left a message regarding resident #9 having personal possession of cigarettes. Continued interview confirmed the Administrator told LPN #4 to let the resident keep the cigarettes stating he/she thought the resident had been approved for independent smoking. Continued interview confirmed resident #9 should not have been allowed to keep cigarettes.</p> <p>Interview on September 27, 2012, at 1:05 p.m., with the Administrator and the Director of Nursing, in the conference room, confirmed the Quality Assurance Committee had not identified the problem of unsafe smoking in order to formulate a plan to address the problem.</p> <p>Refer to F272 for failure to complete smoking assessments.</p> <p>Refer to F280 for failure to update care plans to reflect interventions for residents safe smoking.</p> <p>Refer to F323 for failure to supervise and follow the facility's policy to ensure safe smoking.</p> <p>Refer to F490 for failure to administer the facility in a manner to ensure an effective system was in place to supervise and monitor residents for safe smoking.</p> <p>Interview with the Director of Nursing October 1, 2012, at 12:50 p.m., revealed members of the</p>	F 520	<p>smoke break to be locked up in the medication room(beginning 9/26/12), and with room checks for contraband. Administrative Staff, including the Administrator, Business Office Manager, Activity Director, Human Resources, and Nursing Supervisors, will do observation checks 3x/day, at least 5 days/week for 4 weeks, then 3x/day at least 2x/ week for 3 months, to ensure safe smoking practices, daily to ensure safe smoking practices.</p> <p>How will the corrective action(s) be monitored to ensure the alleged deficient practice(s) will not reoccur; what quality assurance program will be put into place?</p> <ol style="list-style-type: none"> 1. The Social Services Director, DON, ADON, and Maintenance Supervisor will report on the compliance monitoring results to the QA Committee monthly for 3 months beginning in October. 	11/15/12	

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F 520	<p>Continued From page 61</p> <p>Quality Assurance committee (including the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Activity Director, Business Office Manager, Medical Records, Maintenance Supervisor, Certified Dietary Manager, and Housekeeping Supervisor) had met on September 28, 2012, to formulate a plan related to noncompliance with smoking and to develop a plan to ensure resident safety. Continued interview revealed the members of the Quality Assurance committee had revised the facility's Smoking Policy, and inserviced the residents and staff regarding the revised Smoking Policy. Continued interview revealed Social Services had contacted and mailed letters to the families of the residents who smoked, informing them of the facility's Smoking Policy. Continued interview revealed the facility's Medical Director had been made aware of the Immediate Jeopardy on September 28, 2012.</p> <p>The Immediate Jeopardy was effective from September 22, 2012, through October 1, 2012, and was removed on October 1, 2012. An acceptable Allegation of Compliance, which removed the immediacy of the Jeopardy, was received and corrective actions were validated on-site by the survey team on October 1, 2012, through review of facility documents, staff and resident interviews, and observations. The survey team verified the allegation of compliance by:</p> <p>1. Verifying residents #81, #80, and #58 had been reassessed for smoking safety; and verifying the other residents who smoke at the facility had accurate smoking assessments. Accuracy of the smoking assessments was confirmed by the survey team through</p>	F 520			

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F 520	<p>Continued From page 62 observation during smoking sessions.</p> <p>2. Verifying residents #34, #53, #81, #80, #58 and #9 had been educated on the facility's revised smoking policy. The survey team verified the information on interview with resident #58 on September 26, 2012, at 4:00 p.m. The survey team verified the information with resident #53 through observation and interview on September 27, 2012, and interview with #80 on September 27, 2012, at 10:30 a.m.</p> <p>3. Verifying the revision of the facility's smoking policy with acknowledgement of understanding and agreement to the policy by the residents to ensure a safe smoking environment for all residents.</p> <p>4. Verification by the survey team on October 1, 2012, ensured by interviews with multidisciplinary staff, and review of inservice logs confirmed the staff received information regarding the facility's revised smoking policy including staff members are to ensure that all cigarettes and lighters are returned and locked up in the medication room, and that cigarette butts are collected and placed in the locked, metal containers following each smoke break. Residents who are found with cigarettes and/or lighters in their possession will be issued a 30 day discharge notice. Review of documentation confirmed the residents and families of the smoking residents were notified of the revised smoking policy.</p> <p>5. Verifying residents #53, #9, #34, and #58's care plans had been updated to reflect the safety needs for smoking.</p>	F 520			

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F 520	Continued From page 63 Non compliance continues at an "E" level for monitoring corrective actions and evaluation by the facility's Quality Assessment and Assurance Committee. The facility is required to submit a plan of correction for all cited deficiencies.	F 520			